

WELCOME TO OUR OFFICE!

To aid us in providing diagnosis and treatment of your dental needs, please completely fill out this confidential questionnaire.

Patient Name: _____ Preferred Name: _____ Date: _____
 Address: _____ Birth Date: _____
 City, State, Zip: _____ Age: _____ Sex: _____ Marital Status: _____
 Email: _____ Home Phone: _____
 Please, whom may we thank for referring you to our office? _____ Business Phone: _____
 Cell Phone: _____

Person Responsible for Payment

Name: _____ Employer: _____
 Relationship to Patient: _____ Address: _____
 Social Security # of Subscriber: _____ City, State, Zip: _____
 Subscriber's Birth Date: _____ Phone: _____

Health History

Name of your physician: _____ Phone: _____
 How is your general health? (please check) Excellent Good Fair Poor Date of last medical exam: _____
 Do you have, or have you ever had any of the following? (please check)

Heart Disease	Allergies	Diabetes	Thyroid Disease	HIV or Aids
High Blood Pressure	Arthritis	Heart Murmur	Venereal Disease	Liver Disease
Tumor History	Anemia	Seizures	Blood Disorder	Blood Transfusion
Sinus Trouble	Epilepsy	Prosthetic Joints	Radiation Treatment	Abnormal Bleeding
Fainting Spells	Tuberculosis	Rheumatic Fever	Asthma, Emphysema	Kidney Disease
Hepatitis	Stroke	Ulcer		

YES NO Have you been hospitalized and or had surgery within the last two years? (If yes, please explain) _____
 YES NO Are you under care of a physician now? Explain _____
 YES NO Are you taking any medications, drugs or pills? (If yes, list) _____
 YES NO Are you allergic or sensitive to any drug or medication? (If yes, list) _____
 YES NO Do you have any diseases, condition or problem not listed above? (If yes, explain) _____
 YES NO Do you smoke or use tobacco? _____
 YES NO Women: Are you pregnant? _____ Delivery Date: _____
 Remarks: _____

Dental History

YES NO Are you currently in discomfort requiring our immediate attention? _____
 YES NO Have you had regular dental checkups? Date of last visit: _____ What was done? _____
 YES NO Do you fear dental treatment? _____
 YES NO Have there been any complications during previous dental treatment? _____
 YES NO Do your gums bleed during brushing or flossing? _____
 YES NO Have you lost any teeth? Why? _____
 YES NO Are you pleased with the appearance of your teeth? _____
 YES NO Have you ever had any adverse reaction to local anesthetic or objections to its use? _____
 YES NO Do you have any unhealed injuries, inflamed areas or growths in and/or around your mouth? _____
 YES NO Have you ever had any injuries to your skull, face, jaws or teeth? _____
 YES NO Have you ever been taught to control periodontal disease? _____
 YES NO Would you like to change the look of your teeth? _____
 YES NO Do you have chronic headaches, neck or shoulder pain, or all? _____
 YES NO Do you grind or clench your teeth during wake or sleep? _____
 YES NO Do your jaws feel tired or sore when you awake? _____
 YES NO Do your jaw joints grind, pop, clock or lock when you open your mouth? _____

Treatment Authorization and Acknowledgement

I consent to treatment as necessary or desirable to the case of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models, and intraoral examination. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetics and relaxants for completing the necessary dental treatment.

I also acknowledge full responsibility for the payment of such service and agree to pay for them, in full, at the time of service, unless other arrangements are made in advance.

I Have Read and I Understand and Agree to the Above Policy

Date _____